MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

68109

★ Reg. Diat. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Eastern Neck Island--Ferry Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Near Rock Hall Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES DONALD BAKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 8, 1937

8. AGE: Years	Months	Days	If less than one day
8	1	14	...hrs. ...min.

9. Birthplace: Pinney Neck, Kent Co. Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Leslie O. Baker

FATHER — 13. Birthplace: Rock Hall, Md.

MOTHER — 14. Maiden name: Hettie E. Beck

MOTHER — 15. Birthplace: Rock Hall, Md.

16. Informant: Mrs. Leslie O. Baker (Father)

Address: Rock Hall, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/25/45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall, Maryland

18. Funeral director: Marvin V. Williams

Address: Chestertown, Maryland

19. 8/24 (Date rec'd by registrar) 19 45 S. Elwood Bungay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 19 45 at 5:00 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 19 ... to 19 ..., and that I last saw him alive on 19 ...

Did not attend Investigated death and signed certificate as Deputy Med. Exam. Kent Co Md.

Immediate cause of death	DURATION
Accidental Drwoning.	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of

Where did injury occur? Near Rock Hall Md (City or town) (County) Water (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Drowned Injured at work?

23. SIGNATURE: David Howard M.D.

Deputy Med Exam Kent Co Md

Address: Chestertown Md M. D. or other

Date signed: Aug. 24. 45

08110

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(21)

CERTIFICATE OF DEATH

Reg. Dist. No. 202

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Kent
County
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Frances Barnes
3.(b) Social Security Number

4. Sex Female
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife John H. Barnes Deceased
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept 25, 1859
8. AGE: Years 85 Months 10 Days 13 If less than one day ... hrs. ... min.
9. Birthplace Somerset Co. Md
(Town, county, and state)
10. Usual occupation House work
11. Industry or business Home
FATHER 12. Name Mark
13. Birthplace Somerset Co. Md
MOTHER 14. Maiden name Ellen Collins
15. Birthplace Somerset Co. Md
16. Informant Horace M. Barnes
Address Chestertown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 11, 1945 (month) (day) (year)
Cemetery or crematory Quaker Neck (Col) Cem.
Location near Chestertown, Md
18. Funeral director J. Willis Wells
Address Chestertown, Md.
19. Aug. 10, 1945 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8, 1945, at 5 P M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 [illegible] to [illegible] 19 [illegible] and that I last saw h[illegible] alive on [illegible] 19
Immediate cause of death Cardio Renal Disease
DURATION Long yrs
Due to Endocarditis
Due to Rheumatic Fever
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Deputy Medical Examiner, Kent Co. Md
23. SIGNATURE [illegible] M. D. or other
Address Chestertown Md Date signed Aug 10/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Smith

0811

★ Reg. Dist. No. 201

1. PLACE OF DEATH:

County Kent

City or town Kennedyville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent

City or town Kennedyville Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Harrington Boggs.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Henry Thomas Boggs

6.(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Oct 13 1870

8. AGE: Years 74. Months 9 Days 6 If less than one day ____ hrs. ____ min.

9. Birthplace Hazlettsville Del.
(Town, county, and state)

10. Usual occupation Home.

11. Industry or business

FATHER 12. Name James Dunlap

13. Birthplace Ireland.

MOTHER 14. Maiden name Rachel Fisher

15. Birthplace America

16. Informant J P Boggs

Address Wyoming. Dels

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 22/1945. (month) (day) (year)

Cemetery or crematory Silver Lake

Location Dover, Del.

18. Funeral director J B R Fellows

Address Still Pond Md

19. Aug 24 1945 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945 to Aug 18 1945

and that I last saw h[illegible] alive on Aug 18 1945

	DURATION
Immediate cause of death Acute Myocarditis	3 day-
Due to Hypertension	aug. 13/45
Due to	
Other conditions Edema Nephritis	945

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W. Smith M. D. Coroner

Address Chestertown Date signed 8/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

08112

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, institution, or street address where death occurred:
Kent and Queen Anne's
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Galena, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eleanor King Caldwell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): January 31, 1866

8. AGE: Years: 79 | Months: 6 | Days: 5 | If less than one day: hrs. ... min.

9. Birthplace: Cecilton, Cecil, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Francis King
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Sarah Matilda Kernan
15. Birthplace: Pennsylvania

16. Informant: Hosp. Records
Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 8, 1945 (month) (day) (year)
Cemetery or crematory: Galena
Location: Galena, Md.

18. Funeral director: Edward Fabens
Address: Millington, Md.

19. Aug. 7, 1945 (Date received by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 19 45 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to 8-5 19 45
and that I last saw h... alive on 8-4 19 45

Immediate cause of death	DURATION
Fracture left hip	
" left forearm	
Due to: Fall	
Chronic myocarditis with	several years
Due to auricular fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide or homicide~~ Fall in home Date of
Where did injury occur? Millington (City or town) Kent (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Tripped Injured at work? No

23. SIGNATURE: A. L. Dick, M.D. (M. D. or other)
Address: Chestertown, Md Date signed: 8-6-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

08113

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 10 yrs

Hospital, institution, or street address where death occurred:

Washington Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clara Virginia Smith Crew

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Samuel [illegible] Crew

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1859

8. AGE: Years	Months	Days	If less than one day
86	4	26	hrs. min.

9. Birthplace: Carolin e County Maryland (Town, county, and state)

10. Usual occupation: Practial Nurse

11. Industry or business:

FATHER — 12. Name: William E. Smith

13. Birthplace: Talbot County Maryland

MOTHER — 14. Maiden name: Mary E. Williams

15. Birthplace: Queen Anne Co. Maryland

16. Informant: Miss. Elsie Crew

Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 1, 1945 (month) (day) (year)

Cemetery or crematory: Spring Hill Cem.

Location: Easton - Talbot Co. Maryland

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Aug. 31 1945 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29. 1945 19 at 1.05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Aug. 29. 1945

and that I last saw h alive on Aug. 29. 1945

Immediate cause of death: Diabetic Coma.

Due to: Diabetes

Due to: Myocarditis Arterio Sclerosis

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: Days / any yrs / Several yrs.

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Hurst M. D. or other

Address: Chestertown Md Date signed: 8.29.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08114

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred: Kent and Queen Anne's Hosp.
How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent.
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 S. Queen St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Margaret E. Dwyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Dwyer
6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): December 16, 1868

8. AGE: Years	Months	Days	If less than one day
76	7	26	hrs. min.

9. Birthplace: Chestertown, Kent, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John J. Martin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Edes
15. Birthplace: Kent County, Maryland

16. Informant: Hospital records
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14 45 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.

18. Funeral director: J. Ellis Clark
Address: Dealer, Md.

19. Aug. 13, 1945 (Date received by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1945, at 12 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1945, to Aug. 11, 1945; and that I last saw her alive on August 11, 1945.

	DURATION
Immediate cause of death: Cancer & urethra	1 year
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. C. Dick, M.D. (M. D. or other)
Address: Chestertown, Md. Date signed: 8-11-45

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08115

★ Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Rural - Pomona
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pomona
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THEODORE FRANCIS FLANDREAU

3.(b) Social Security Number: 042-18-9861

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of ~~husband~~ wife: CAROLINE S FLANDREAU
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): AUG. 24, 1879

8. AGE: Years	Months	Days	If less than one day
66	11	23	....hrs. ....min.

9. Birthplace: NEW YORK (Town, county, and state)
10. Usual occupation: GUARD
11. Industry or business: DEFENSE PLANT

FATHER
12. Name: Theodore F. Flandreau
13. Birthplace: New York City

MOTHER
14. Maiden name: Mary Eliz. Onderdonk
15. Birthplace: New York

16. Informant: Mrs. Caroline S. Flandreau
Address: Chestertown R.D. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18.1945 (mooth) (day) (year)
Cemetery or crematory: White Plains Rural Cemetery
Location: White Plains, N. Y.

18. Funeral director: Marvin V. Williams
Address: Chestertown, Maryland.

19. Aug. 17 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 16 1945 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 13 1945 to August 16 1945 and that I last saw h~~im~~ alive on August 15 1945

Immediate cause of death	DURATION
Carcinoma of Prostate	1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Cancer of Prostate
John Hopkins Dr. Date of op. 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank N. Smith, M. D. or other
Address: Chestertown. Md. Date signed: 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

08116 203

★ Reg. Diat. No. .....

1. PLACE OF DEATH:

County ..... Kent

City or town ..... Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... life

Hospital, Institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. County ..... Kent

City or town ..... Rock Hall.

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Louise Ford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	col	married

6.(b) Name of husband or wife ..... Harry Ford

6.(c) If alive, give age ..... 70 years

7. Birth date of deceased (mo., day, yr.) June 3/1877

8. AGE:

Years	Months	Days	If less than one day
68	7	2	..... hrs. ..... min.

9. Birthplace ..... Rock Hall, Md (Town, county, and state)

10. Usual occupation ..... Housework

11. Industry or business ..... own.

FATHER 12. Name ..... Samuel Gaines

FATHER 13. Birthplace ..... Rock Hall

MOTHER 14. Maiden name ..... Jane Butler

MOTHER 15. Birthplace ..... Rock Hall

16. Informant ..... Harry Ford

Address ..... Rock Hall

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 8 1945 (month) (day) (year)

Cemetery or crematory ..... Shrapstown.

Location ..... Rock Hall Md.

18. Funeral director ..... Asbury Henry

Address ..... Chestertown Md.

19. 8/7 1945 (Date rec'd by registrar) S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... August 5 1945 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1945 to Aug 5 1945 and that I last saw h... alive on Aug 4 1945

Immediate cause of death	DURATION
chron Endo-myocarditis	
Due to Ca of rectum	
Due to chron bronchitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE ..... Albert A Burgard M. D. or other

Address ..... Rock Hall, Md Date signed 8/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

08117

Reg. Dist. No. 201

1. PLACE OF DEATH:
County Grey
City or town Owen Sound
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) Five weeks
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infant, give residence of mother)
State N.S. County Grey
City or town Owen Sound Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thurlow Fraser

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jane Armstrong Fraser
B(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 18. 1870

8. AGE: Years 75 | Months | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace Ottawa Canada
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name Robt Fraser
FATHER 13. Birthplace Ireland

MOTHER 14. Maiden name Louisa Jane Hudman
MOTHER 15. Birthplace Canada

16. Informant Jane Armstrong Fraser
Address Owen Sound Ont.

17. Burial Date thereof Aug 16 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenwood Cemetery
Location Owen Sound Ontario Canada

18. Funeral director J. R. Gallows
Address Still Pond, Md.

19. Aug 10 1945 J. H. Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to 1945 and that I last saw ... alive on ... 1945

Immediate cause of death (a) Coronary Thrombosis
Due to (b) Hypertension
Due to (c)
Other conditions

DURATION (a) Hrs (b) Yrs (c)

(Include pregnancy within 3 months of death)
Major findings:
Of operations No
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? No (City or town) (County) (State)
(Street, home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Jack Wales M.D.
M. D. or other
Address Owen Sound Ont. Date signed Aug 10/45

08118

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Piney Neck - Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Piney Neck

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rock Hall

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John W Grant

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	

6.(b) Name of husband or wife: (Mrs) Ida Auld Grant

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2 1862

8. AGE:

Years	Months	Days	If less than one day
83	2	1	hrs. min.

9. Birthplace: Rock Hall Kent Co. Md.
(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business:

FATHER
12. Name: Richard W. Grant
13. Birthplace: Rock Hall. Md.

MOTHER
14. Maiden name: Mary Coleman.
15. Birthplace: Rock Hall Maryland

16. Informant: Mrs. Christopher Grant.

Address: Rock Hall. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall Maryland.

18. Funeral director: Marvin O. Williams

Address: Chestertown. Maryland.

19. 8/7 (Date rec'd by registrar) 1945 Edward Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 6 1945 at 11:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945 to Aug 6 1945 and that I last saw h.. alive on Aug 6 1945

Immediate cause of death	DURATION
old age	
chron. Endo-myocarditis	
Due to: Arteriosclerosis chron.	
Due to: chron. Endocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 8/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9/8 - L7/v

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

08119

★ Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.

County Kent

City or town Smith ville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Boston R.R. Md

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Smithville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clarence Earnest Hastings

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Belle Price

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 14 1878

8. AGE: Years 67 | Months 3 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace Bridgeville Delaware

(Town, county, and state)

10. Usual occupation Miller

11. Industry or business

FATHER 12. Name of Harry Hastings

13. Birthplace Delaware

MOTHER 14. Maiden name Lizzie Mc Cauley

15. Birthplace Delaware

16. Informant Mrs. Chas Hastings

Address Boston R.R. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/19/45 (month) (day) (year)

Cemetery or crematory Chester

Location Chestertown Maryland

18. Funeral director Marvin C. Williams

Address Chestertown Maryland

19. Aug. 19, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1945 at 12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1944, to Aug 17 1945

and that I last saw him alive on August 17 1945

	DURATION
Immediate cause of death: Cerebral sclerosis	10 yrs
Due to: Rupture Pneumonia	1944
Due to:	
Other condition: Cerebral sclerosis	1944

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Smith M. D. or other

Address Chestertown Md Date signed 8/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

0812 03

Reg. Dist. No. 2

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County: Kent

City or town: Rock Hall Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carrie Virginia Ackers Hubbard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	married

8.(b) Name of husband or wife: Edwin Morgan Hubbard

8.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 3-29-1888

8. AGE: Years: 57 | Months: 4 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Rock Hall Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: George Ackers

FATHER — 13. Birthplace: Hartford County

MOTHER — 14. Maiden name: Martha Elizabeth Seward

MOTHER — 15. Birthplace: Rock Hall Md.

16. Informant: Letia Rebecca Stevens (Sister)

Address: Rock Hall, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-7-45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall Md

18. Funeral director: Willis Wells

Address: Chestertown Md.

19. Aug 6 1945 (Date rec'd by registrar) S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1945, at 8 36 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 20 P.M Aug 5 1945, to 8 35 P.M Aug 5 1945 and that I last saw h... alive on Aug 5 1945

Immediate cause of death	DURATION
acute Pulmonary Edema	
Congestive Hypertension	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md. Date signed 8/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

08121

Reg. Dist. No. 2021

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Kent and Queen Annes Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Gotts
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Anne Johnston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): February 3, 1943

8. AGE:

Years	Months	Days	If less than one day
2	6	24	... hrs. ... min.

9. Birthplace: Chestertown, Kent, Maryland (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Everett Johnston
13. Birthplace: Kent County, Maryland

MOTHER
14. Maiden name: Helen Semans
15. Birthplace: Templeville, Maryland

16. Informant: Hospital Records
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30 1945 (month) (day) (year)
Cemetery or crematory: Millington
Location: Millington Md.
18. Funeral director: Edward Pellum
Address: Millington Md.

19. Aug 27, 1945 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1945, at 8:20 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-23 1945, to August 27 1945
and that I last saw h.er alive on August 27 1945

	DURATION
Immediate cause of death: Peritonitis	6 days.
Due to: Appendicitis	7 days.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Purulent appendicitis
Date of op. 8-23-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. C. Dick, M.D. (M. D. or other)
Address: Chestertown, Md. Date signed 8-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11a)

CERTIFICATE OF DEATH

08122

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Kent & Queen Anne General Hospital

How long in hospital or institution? 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Fairlee, Chestertown R.D. No

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Wayne Lewerton

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 8 1945

8. AGE: Years | Months | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Chestertown Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Albert S. Lewerton

FATHER — 13. Birthplace: Fairlee Kent Co Md

MOTHER — 14. Maiden name: Mildred Elizabeth Metz

MOTHER — 15. Birthplace: Baltimore Co. Md

16. Informant: Mrs Mildred Lewerton

Address: Chestertown R.D. Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: August 19 1945 (month) (day) (year)

Cemetery or crematory: CHESTER CEM.

Location: CHESTERTOWN, MARYLAND

18. Funeral director: J. Willis Wells

Address: Chestertown, maryland.

19. Aug. 19 1945 (Date rec'd by registrar) Clark L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1945, at 10:30 a M

21. I CERTIFY that death occured on the date above stated; that I attended deceased from Aug. 1945 to Aug 17 1945

and that I last saw h... alive on Aug 17 1945

Immediate cause of death	DURATION
Acquired Atelectasis	2 days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Pulmonary Emphysema 2 days

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Frank M Smith M. D. or other

Address: Chestertown Md Date signed: 8/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 97 AUG 9 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08123 ★ Reg. Dist. No. 303.

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? al Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Hugh McCloskey

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 1874

8. AGE: Years	Months	Days	If less than one day
71 70			hrs. min.

9. Birthplace: Kent County Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farming

FATHER 12. Name: James Edward McCloskey

13. Birthplace: Ireland

MOTHER 14. Maiden name: Margaret Owns

15. Birthplace: Ireland.

16. Informant: Frank McCloasney

Address: Rock Hall Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 4-45 (month) (day) (year)

Cemetery or ~~crematory~~: St Johns

Location: Rock Hall Md

18. Funeral director: Edgar L Lane

Address: Church Hill Md

19 Aug 3 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2. 1945 19 ..., at about 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend Investigated death 19 ... 19 Exam. and that I last saw h... alive on ... 19 ... signed certificate as Deputy Med.

Immediate cause of death	DURATION
Cardio Renal Disease	
Due to: Acute Alcoholism	Many years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Med. Exam Kent Co Md. M.D. or other

Address: Chestertown Md Date signed: Aug 2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

08124

CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Kent & Queen Anne Counties Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Howard Dale Rees

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Ella Stevwns Rees

Living 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 19, 1876

8. AGE: Years	Months	Days	If less than one day
69	0	29	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Abel J. Rees

13. Birthplace: Kent Co. Md.

MOTHER 14. Maiden name: Mary Jones

15. Birthplace: Kent Co. Md.

16. Informant: Walter Rees (son)

Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 20, 1945 (month) (day) (year)

Cemetery or crematory: Saint Paul Cemetery

Location: Near Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Aug. 18, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1945, at 11.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944, to August 18, 1945

and that I last saw alive on August 18, 1945

Immediate cause of death	DURATION
Thalegnant Hypertension	1944
Due to Uterine adenoma	1944
Due to Chronic Myocarditis	1944
Other conditions Nephritis	1945

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank W. Smith M. D. or coroner

Address: Chestertown Md. Date signed 8/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

68125

Reg. Dist. No. 204

1. PLACE OF DEATH:

County Kent

Farrad near St. Johns Church

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

Farrad near St. Johns Church

(If outside city or town limits, write RURAL and give nearest town)

Street No. Chestertown R R No

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nettie I Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Wallace P. Taylor

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1862

8. AGE:

Years	Months	Days	If less than one day
82	4	18	hrs. min.

9. Birthplace Brooklyn N Y (Town, county, and state)

10. Usual occupation Teacher Retired

11. Industry or business

FATHER 12. Name Noble A Taylor

13. Birthplace Sheybrook + Canada

MOTHER 14. Maiden name Phoba Stockbridge

15. Birthplace New York State N Y

16. Informant Mrs Edmund Stevens

Address Chestertown R R No

17. Cremation Date thereof Aug 11, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SILVER BROOK CREMATORY

Location WILMINGTON, DELAWARE

18. Funeral director J. Willis Wells

Address Chestertown, Maryland.

19. August 7 1945 F. M. Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 1939, to August 6 1945

and that I last saw her alive on August 6 1945

Immediate cause of death	DURATION
Cardiac Muscular Disease	1939
Due to	
Due to	
Other conditions Lupus Erythematosus (Include pregnancy within 3 months of death)	many years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Smith M. D., or other

Address Chestertown Md Date signed 8/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

08126 701

★ Reg. Dist. No. .....

1. PLACE OF DEATH:

County Kent

City or town Stillpond

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? entire life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Stillpond

(If outside city or town limits, write RURAL and give nearest town)

Street No. Henry Davis Farm

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Areba Ray Wilson

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	widow

6.(b) Name of husband or wife James L. Wilson deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 4. 1891

8. AGE:	Years	Months	Days	If less than one day
	54	6	3	..... hrs. ..... min.

9. Birthplace Fountain, Kent Co. Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Midwife 5 years

FATHER 12. Name George Hackett

13. Birthplace Kent Co. Md

MOTHER 14. Maiden name Victoria Dawson

15. Birthplace Kent Island Q.A. Co. Md

16. Informant Mary D. Woolley

Address Stillpond Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10 1945 (month) (day) (year)

Cemetery or crematory Fountain

Location Worton Md Rural

18. Funeral director B R Fellows

Address Still Pond Md.

19. Aug 10 1945 (Date rec'd by registrar) J M Leach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945 at 3.15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1945, to August 6 1945

and that I last saw her alive on August 3 1945

Immediate cause of death	DURATION
Cerebral Vascular disease	1945
Due to	
Due to Senile Anaemia	1945
Other conditions Diabetes	1928

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Fred W. Smith M. D. or other

Address Chestertown Date signed 8/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15